Texas Department of Aging
and Disability Services

Form 3671-H
June 2013-E

Community Based Alternatives

Dental Services

		(This Space For DADS Use Only)
1. Applicant/Individual Name	2. Medicaid No.	3. Effective Date
4. DADS Case Manager		5. Provider Vendor No.

Dental Evaluations and Treatment Plans

6. Dental Evaluations	7. TPR or Copay for Dental Evaluations and Treatments	8. Estimated Cost	9. Requisition Fee Not Valid as of 12-1-11
☐ Non-Emergency $200 or Less Without Prior Approval – One Per ISP Year			
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
☐ Specialized $200 or Less Without Prior Approval			
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
☐ Additional Non-Emergency After One Per ISP Year and All Evaluations More Than $200 - Requires Prior Approval			
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
☐ Dental Treatment Plans			
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		
	☐ **1-Yes** ☐ **2-No** ☐ **3-Copay**		

(Attach additional pages, if needed.)

	10. Total Estimated Cost	
Boxes 10 –15 For DADS Use Only — **Previously Authorized this ISP Year +**	**11.**	**13.**
Subtotal =	**12.**	**14.**

16. Comments/Schedules/Progress Reports – attach additional pages if needed:

Total of Boxes 12 + 14 = **15.**

Note: Box 15 (total of dental evaluations and dental treatments) cannot exceed $5,000 annually.

Certification By Interdisciplinary Team Members: The waiver services identified above for this applicant/individual are necessary to prevent nursing facility placement and are appropriate to meet the needs of the applicant/individual in the community.

Signature–HCSSA Nurse Assessor	Date	Signature–Applicant/Individual/ Responsible Party	Date
Signature–DADS Case Manager	Date	Signature–HCSSA Representative (if required)	Date

☐ **Applicant/individual/responsible party and HCSSA representative signatures on Form 3671-2 at initial certification and annual redetermination.**